

32BJ Health Fund Response to CMS Hospital Price Transparency RFI

July 21, 2025

To: Centers for Medicare & Medicaid Services

Re: Request for Information on Hospital Price Transparency Accuracy and Completeness

Introduction

The 32BJ Health Fund is an unusually effective collaboration between a labor union and management to provide affordable, comprehensive, and innovative health coverage to working-class people. We aggregate employer contributions from 5,000 employers, ranging from many small businesses to global real estate firms, and use these contributions to provide benefits to 200,000 members of the SEIU Local 32BJ union and their families. The union members are cleaners, property maintenance workers, doorpersons, security officers, window cleaners, building engineers, school and food service workers, and airport workers in over 10 states and Washington, DC.

Our comments build upon our September 2023 response to CMS-1786-P and reflect our ongoing learning as users of hospital machine-readable files (MRFs) for direct contracting negotiations and member benefit design. As a purchaser of healthcare services, we have extensive practical experience with the challenges and opportunities of using hospital price transparency data.

Question 1: Defining "Accuracy" and "Completeness"

Should CMS specifically define the terms "accuracy of data" and "completeness of data" in the context of Hospital Price Transparency requirements, and, if yes, then how?

Yes, CMS should establish clear, operational definitions for both accuracy and completeness based on practical user needs and technical implementation requirements.

Defining "Completeness" Based on our data analysis experience, completeness should be defined as hospitals providing pricing information for all procedures (CPTs/DRGs) that they actively perform. Currently, we don't always have prices for complete sets of codes for services we know hospitals provide, creating gaps that undermine comparative analysis. We recommend CMS define complete data as:

- Inclusion of all services the hospital markets or advertises
- Clear indication when services are truly not offered vs. data omission

Defining "Accuracy" Accuracy should encompass both rate precision and contextual reliability. We recommend CMS define accurate data as:

- Rates within a specified threshold (e.g., 5%) of actual contracted terms
- Clear labeling distinguishing negotiated rates from estimates or algorithms
- Inclusion of accuracy or confidence scores to help users assess data reliability
- Proper coding and categorization using standardized systems

Enhanced Practical Implementation Standards CMS should require hospitals to attest not only to the accuracy and completeness of their data but also to provide basic data quality metrics that help users understand data reliability and appropriate usage. Based on our experience, hospitals may believe their data meets accuracy standards while still producing files with significant usability limitations.

Recommended additions:

- Accuracy or confidence scores for each reported rate to help users assess data reliability
- Hospitals should be required to clearly identify and categorize the plan types they contract with, including:
 - Plan product categories (Medicaid, Essential Plan, Commercial, Medicare Advantage)
 - Commercial plan structures (PPO, HMO, POS)
 - Plan size indicators (large group, small group, individual market)
 - Special population plans (student, government employee, union-specific)

Question 2: Specific Concerns About Accuracy and Completeness

What are your concerns about the accuracy and completeness of the Hospital Price Transparency Machine Readable Files data? Please be as specific as possible.

Our analysis of MRF data for use in direct contracting negotiations reveals multiple accuracy and completeness issues that fundamentally limit the data's utility:

Outpatient vs. Inpatient Data Reliability Disparities While inpatient data has proven relatively reliable for cross-carrier comparisons—allowing us to calculate an inpatient base rate that is used consistently across claims pricing—outpatient data presents severe comparability challenges. In our analysis of rates from a major academic medical center that serves our members, we discovered that carriers use fundamentally different pricing methodologies that make meaningful comparisons impossible. Some carriers negotiate bundled outpatient rates while others price services item-by-item, creating rate differences so significant they appear erroneous.

Cross-Carrier Comparison Failures During our rate analysis, we encountered situations where a certain carrier's rates appeared significantly lower than ours. Additional analysis revealed this wasn't necessarily indicative of lower negotiated rates, but rather different pricing structures that made the MRF data misleading for comparative analysis. The way different carriers negotiate prices with hospital facilities varies significantly, making direct rate comparisons often unreliable.

Missing Data and Multiple Rate Issues We frequently encounter missing data where hospitals fail to report rates for services they provide, or conversely, multiple rates are present for the same service without clear explanation of when each applies. This creates uncertainty about which rate represents the actual contracted amount and makes it difficult to determine fair pricing benchmarks.

Plan Identification and Classification Challenges It is difficult to know which commercial plan listed in MRF files best reflects our plan structure, and plan naming conventions create significant confusion. Plan names can be misleading when hospitals list multiple similar plans without clear differentiation. For example, at one major health system where we have significant member utilization, the HMO rates most accurately align with our PPO rates, but this is discoverable only through claims data comparison—

information unavailable to most users. Plan categorizations are often unclear, making it challenging to identify comparable rates for analysis.

Technical File Quality Issues We consistently encounter basic technical problems that prevent proper data analysis. Many JSON files contain parsing errors, including unmatched curly brackets that require extensive cleaning before analysis can begin. These fundamental formatting issues suggest inadequate quality control before publication.

Inconsistent Coding and Categorization Hospitals frequently use inconsistent coding systems, particularly for outpatient services. Certain codes will be under revenue codes instead of being under HCPCS codes, creating comparison difficulties and undermining standardization efforts.

Missing Contextual Information MRF data provides rates without some of the crucial contextual information needed for accurate price comparisons. Healthcare pricing involves multiple layers with complex rules governing when different rates apply, including length of stay outlier adjustments, bundling arrangements, and procedure combinations that significantly affect actual costs.

Question 3: Impact on Data Usage Effectiveness

Do concerns about accuracy and completeness of the MRF data affect your ability to use hospital pricing information effectively?

Data quality concerns limit our ability to use hospital pricing information effectively. Despite our sophisticated data analytics capabilities and partnership with third-party vendors, MRF data has useful applications, but cannot be used as broadly as intended.

Technical File Processing Challenges Standardized templates have not eliminated fundamental technical barriers that consume significant processing time and resources. JSON files frequently contain parsing errors that require extensive cleaning before analysis can begin. File processing can take days for a series of files, depending on size and format complexity. The introduction of standardized templates has caused these files to balloon in size as code fields 2 and 3 came about, with JSON nested dictionaries being resource intensive to process.

Limited Scope of Reliable Analysis Our intended use case was comprehensive cross-carrier rate comparisons to inform direct contracting negotiations. However, data quality issues forced us to narrow our analysis scope. While inpatient data is reliable and can be used for directional guidance, outpatient rate comparisons—critical for most healthcare services—cannot be conducted reliably across carriers.

Continued Vendor Dependency We continue to rely on third-party vendors for MRF data processing and analysis, indicating that standardized templates have not eliminated the technical barriers to direct data use. The complexity of validating data quality and determining which rates to use requires specialized expertise that smaller payers may not have access to.

Impact on Fair Pricing Assessment These data quality issues make it very difficult to know what constitutes fair pricing and which rates are accurate. Without reliable data, we cannot effectively assess whether our contracted rates are competitive or reasonable compared to market standards.

Question 5: Improving Compliance and Enforcement

What specific suggestions do you have for improving the HPT compliance and enforcement processes?

Building upon our comprehensive 2023 recommendations, we propose several critical improvements:

Mandatory File Validation Requirements CMS should mandate that all MRF files pass through a JSON validator tool before publication. Currently, some JSON files have parsing errors including basic formatting issues such as extra curly brackets that prevent proper data ingestion. This creates an unnecessary barrier for all data users and suggests not all hospitals are conducting basic quality checks before publication.

Standardized Update Windows The current annual update requirement allows hospitals too much flexibility in submission timing. Currently, hospitals may update annually but each hospital can select when they update, potentially updating their 2025 numbers in Q4 of the year. We recommend requiring hospitals to update their files earlier in the year within standardized quarters (Q1/Q2) to ensure timely availability of current pricing information.

Enhanced Public Compliance Reporting Building on our 2023 recommendations, we continue to urge CMS to publicize when assessments of compliance are started, in progress, and completed (regardless of outcome) to increase clarity and confidence in the publicly posted files. This transparency would help payers understand the reliability of specific hospital data.

Strengthened Enforcement Actions for Large Hospital Systems Current penalties appear insufficient to drive compliance among large hospital systems. We recommend escalating consequences for repeat violations and more aggressive enforcement timelines, particularly for large hospitals in consolidated markets where limited competition already disadvantages payers.

Claims Data Cross-Validation Requirements Building on our experience validating MRF data against claims data, CMS should establish systematic requirements for hospitals to verify their reported rates against actual payment patterns. The complex logic and salient terms between payers and hospitals significantly affect final payments, and these contextual factors should be incorporated into validation processes.

Question 6: General Quality Improvements

Do you have any other suggestions for CMS to help improve the overall quality of the MRF data?

Beyond the technical and enforcement improvements outlined above, we recommend several additional measures to enhance MRF data quality and usability:

Commercial Plan Identification Requirements Hospitals should be required to clearly flag and categorize commercial plans to distinguish them from government, student, or other specialized plans that may not reflect standard commercial rates. Clear identification of plan types (PPO, HMO, etc.) is essential for meaningful rate comparisons.

Salient Terms and Pricing Context Hospitals should provide information about the contractual rules and salient terms that affect pricing. Rates alone are insufficient for understanding actual payment amounts, as various adjustments, bundling rules, and payment terms significantly impact final costs.

Enhanced Context for Pricing Complexity Healthcare pricing involves multiple layers with complex rules governing when different rates apply. We recommend hospitals provide:

- Length of stay outlier adjustments and thresholds
- Information about bundled vs. unbundled service pricing
- Frequency statistics (e.g., 90% of the time a specific code results in a particular payment amount)
- Clear indication of which rates are commonly used vs. theoretical

Standardized Code Mapping and Accuracy Scores We recommend:

- Mandatory use of standardized code sets (CMS DRGs vs. AP-DRGs)
- Accuracy or confidence scores for each rate to help users assess reliability
- Clear indicators distinguishing negotiated rates from estimates to address misleading rate comparison issues
- Cross-reference mapping when different coding systems are used

Complete Service Coverage Requirements Hospitals should be required to report rates for all services they provide, with clear indicators when services are truly not applicable vs. omitted.

Accessibility Improvements for Non-Technical Users Given the complexity of current files, CMS should consider simplified formats or summary tools that allow consumers to access key pricing information without requiring specialized technical expertise or expensive vendor relationships.

Conclusion

The 32BJ Health Fund supports CMS's continued efforts to improve hospital price transparency and appreciates the opportunity to provide input based on our practical experience using MRF data. As a self-insured fund, improving and enhancing public hospital price transparency data is critically important for us to be able to benchmark and validate the prices we pay for healthcare services.

The recommendations outlined above reflect real-world challenges encountered by sophisticated data users and would significantly improve the utility of hospital pricing information for comparative analysis, contract negotiations, and benefit design decisions.

We urge CMS to prioritize technical standardization, enhanced enforcement, and practical usability improvements that will help achieve the transparency initiative's goals of promoting competition and empowering healthcare consumers.

Respectfully submitted,



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